

August 24, 2000

[This letter was sent to each
State's Attorney in Maryland]

Dear State's Attorney:

As a result of a television program next month, public attention is likely to be focused again on issues of end-of-life medical care and physician-assisted suicide. "On Our On Terms," a four-part series from Bill Moyers, will be shown on Maryland Public Television Sunday, September 10 through Wednesday, September 13. The third program in the series will include a look at the physician-assisted suicide debate. In conjunction with the program, community forums on end-of-life care will be held throughout the State. These forums are being sponsored locally by Maryland Public Television, Hospice Network of Maryland, Enoch Pratt Free Library, Baltimore County Public Library, and other Maryland public libraries and hospice organizations.

In the event that questions come to you about enforcement of Maryland's Assisted Suicide Act, Article 27, §416 of the Code, I wanted to provide you with what I hope is useful guidance about how this law applies and, especially, why it does *not* apply to medically appropriate measures to relieve pain and other symptoms. Article 27, §416 distinguishes between assisting suicide and prescribing or administering pain medication at a level that might cause or hasten death. It provides that "a licensed health care professional" who "administers, prescribes, or dispenses medications or procedures to relieve pain, *even if the medication or procedure may hasten or increase the risk of death*, is not in violation of ... [the prohibition against assisting suicide] unless the medications or procedures are *knowingly administered, prescribed, or dispensed to cause death*." (Emphasis added.)

The legislation thus assures Maryland clinicians that effective relief of pain and other symptoms in their patients remains consistent with State policy. Although the statute

specifically refers only to pain, use of medications to alleviate other symptoms, like air hunger, should be regarded in the same light. Clinicians should not be concerned that they will be accused of assisting a suicide when they make legitimate medical decisions to ease a patient's pain or suffering and the patient subsequently dies. The Legislature correctly perceived that such a concern could lead to less aggressive symptom management for suffering patients. Moreover, recent medical research indicates that, in fact, increased levels of morphine or similar opioids for symptom control do not shorten patients' lives. Andrew Thorns and Nigel Sykes, *Opioid Use in Last Week of Life and Implications for End-of-Life Decision-Making*, 356 *Lancet* 298 (2000).

Should a questionable case be brought to your attention, you may find helpful the following guidelines, which, while not meant to be definitive or exhaustive, are indicative of an intent to prescribe or administer medication to relieve symptoms, rather than to cause death:

1. The patient is seriously ill.
2. The patient's symptoms (such as pain, shortness of breath, or delirium) are not otherwise controlled, and the symptoms are documented in the patient's record.
3. Symptom management has been defined as a goal of care.
4. The patient's advance directive, if one is known to the clinician, has been reviewed and is consistent with the actions taken.
5. Medication is initiated at a level consistent with the patient's tolerance levels and extent of symptoms and is adjusted (titrated) to achieve adequate symptom control.
6. Medication use is properly documented.

Application of these guidelines to a particular case would require a detailed assessment of the patient's clinical course. We are familiar with medical experts who could provide advice about any specific situations that may arise.

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If you have questions about this issue or want further information, please contact Assistant Attorney General Jack Schwartz at (410) 576-6327.

Very truly yours,

J. Joseph Curran, Jr.
Attorney General